AMENDED IN ASSEMBLY APRIL 19, 2005

CALIFORNIA LEGISLATURE—2005–06 REGULAR SESSION

ASSEMBLY BILL No. 757

Introduced by Assembly Member Chan

February 18, 2005

An act *to amend Section 511.3 of, and to amend, repeal, and add Section 511.1 of, the Business and Professions Code, to amend Section 1375.7 of, and to amend, repeal, and add Section 1395.6 of, the Health and Safety Code, to amend Section 10178.4 of, and to amend, repeal, and add Section 10178.3 of, the Insurance Code, and to add Section 4609.5 to, and to amend, repeal, and add Section 4609 of, the Labor Code,* relating to health care.

LEGISLATIVE COUNSEL'S DIGEST

AB 757, as amended, Chan. Health care providers: contracts.

Existing law*, the Knox-Keene Health Care Service Plan Act of 1974, the willful violation of which is a crime,* provides for the regulation of health care service plans by the Department of Managed Health Care~~, and~~*. Existing law provides* for the regulation of disability insurers by the Insurance Commissioner. ~~Existing law, with respect to contracts providing for the payment of preferred reimbursement rates by payors or health care services rendered by health care providers, imposes certain disclosure and related requirements on contracting agents, as defined, who sell, lease, assign, transfer, or convey a list of contracting providers and their contracted preferred reimbursement rates to other payors or contracting agents.~~

~~This bill would make specified findings and declarations with regard to silent preferred provider organizations and the resulting unfair practices and harm to patients. The bill would declare the intent~~

~~of the Legislature to enact legislation that would provide more equity in contracting in order to promote patient care.~~

Existing law requires a contracting agent, as defined, that sells, leases, assigns, transfers, or conveys a list of contracted health care providers and their contracted reimbursement rates to a payors to make specified disclosures to providers and to allow providers to decline to be on the list. Existing law requires the payor to provide an explanation of benefits or explanation of review, and, upon the written request of a provider who has received a claim payment, to make a demonstration that it is entitled to pay the contracted rate.

This bill would, effective July 1, 2006, prohibit a contracting agent from selling, leasing, assigning, transferring, or conveying its list of contracting health providers and their contracted rates unless certain conditions are met, including having a direct contract with the provider that meets specified criteria, obtaining affirmative written consent from the provider, and making certain disclosures. The bill would also, effective July 1, 2006, revise the requirements that a payor claiming eligibility to a contracted rate must meet, and would provide that a payor's determination of entitlement to pay a contract rate is refuted if a provider supplies specified documentation. The bill would make other related changes.

Because this bill would create new requirements for health care service plans, the willful violation of which would be a crime, it would impose a state-mandated local program.

The California Constitution requires the state to reimburse local agencies and school districts for certain costs mandated by the state. Statutory provisions establish procedures for making that reimbursement.

This bill would provide that no reimbursement is required by this act for a specified reason.

Vote: majority. Appropriation: no. Fiscal committee: ~~no~~ *yes*. State-mandated local program: ~~no~~ *yes*.

The people of the State of California do enact as follows:

SECTION 1. The Legislature hereby finds and declares all of the following:

(a) Silent preferred provider organizations result when contracting agents sell or rent the names and reimbursement rates of their contracted health care providers to third parties~~, allowing~~

~~contracting agents to gain additional revenue and third parties to take advantage of a provider's discounted rate, even though they may not be entitled to it.~~.

(b) Despite current protections in the law, many health care providers are unaware that they have agreed to have their names and rates sold to other payors~~, often for no benefits in return.~~

~~(c) While current law, authored initially by Senator Brulte in Senate Bill 559 of the 1999 Legislative Session, attempted to prevent these unfair practices, loopholes remain, such as the following:~~

~~(1) Providers are still being forced to allow the selling or renting of their names and contract rates through "take it or leave it" contracts.~~

~~(2) Other payors often take advantage of discounted contracted rates without providing any benefits to the provider, such as the referral of patients.~~

~~(3) Provider~~

(c) In some instances, provider names and discounted rates are being sold or rented to other payors offering a completely different product that requires a different level and scope of service than that contracted for in the underlying contract.

~~(4) All of the above still occurs,~~ *This can sometimes happen* even after termination of the underlying contract.

~~(d) Furthermore, patients are harmed by the described activities in the following ways:~~

~~(1) Patients' expectations concerning the level of care provided by out-of-network physicians are defeated.~~

~~(2) Their providers are being forced to accept larger patient loads than they can financially or ethically handle, potentially compromising quality and care.~~

~~(3) Patients are being billed by providers that are unaware that their name and discounted rates were sold to the patient's payor.~~

~~(4) Patients are experiencing decreased access to care altogether, as providers are increasingly unable to enter into managed care contracts with such unfair provisions.~~

~~(e) More protections are needed to end these abusive practices. The Legislature intends to enact legislation that would provide more equity in contracting in order to promote patient care.~~

(d) The Legislature intends to enhance disclosure and contracting provisions so that providers and patients are more

fully informed about network participation and discounted provider rates.

SEC. 2. Section 511.1 of the Business and Professions Code is amended to read:

511.1. (a) In order to prevent the improper selling, leasing, or transferring of a health care provider's contract, it is the intent of the Legislature that every arrangement that results in a payor paying a health care provider a reduced rate for health care services based on the health care provider's participation in a network or panel shall be disclosed to the provider in advance and that the payor shall actively encourage beneficiaries to use the network, unless the health care provider agrees to provide discounts without that active encouragement.

(b) Beginning July 1, 2000, every contracting agent that sells, leases, assigns, transfers, or conveys its list of contracted health care providers and their contracted reimbursement rates to a payor, as defined in subparagraph (A) of paragraph (3) of subdivision (d), or another contracting agent shall, upon entering or renewing a provider contract, do all of the following:

(1) Disclose whether the list of contracted providers may be sold, leased, transferred, or conveyed to other payors or other contracting agents, and specify whether those payors or contracting agents include workers' compensation insurers or automobile insurers.

(2) Disclose what specific practices, if any, payors utilize to actively encourage a payor's beneficiaries to use the list of contracted providers when obtaining medical care that entitles a payor to claim a contracted rate. For purposes of this paragraph, a payor is deemed to have actively encouraged its beneficiaries to use the list of contracted providers if one of the following occurs:

(A) The payor's contract with subscribers or insureds offers beneficiaries direct financial incentives to use the list of contracted providers when obtaining medical care. "Financial incentives" means reduced copayments, reduced deductibles, premium discounts directly attributable to the use of a provider panel, or financial penalties directly attributable to the nonuse of a provider panel.

(B) The payor provides information directly to its beneficiaries, who are parties to the contract, or, in the case of workers' compensation insurance, the employer, advising them

of the existence of the list of contracted providers through the use of a variety of advertising or marketing approaches that supply the names, addresses, and telephone numbers of contracted providers to beneficiaries in advance of their selection of a health care provider, which approaches may include, but are not limited to, the use of provider directories, or the use of toll-free telephone numbers or internet web site addresses supplied directly to every beneficiary. However, internet web site addresses alone shall not be deemed to satisfy the requirements of this subparagraph. Nothing in this subparagraph shall prevent contracting agents or payors from providing only listings of providers located within a reasonable geographic range of a beneficiary.

(3) Disclose whether payors to which the list of contracted providers may be sold, leased, transferred, or conveyed may be permitted to pay a provider's contracted rate without actively encouraging the payors' beneficiaries to use the list of contracted providers when obtaining medical care. Nothing in this subdivision shall be construed to require a payor to actively encourage the payor's beneficiaries to use the list of contracted providers when obtaining medical care in the case of an emergency.

(4) Disclose, upon the initial signing of a contract, and within 30 calendar days of receipt of a written request from a provider or provider panel, a payor summary of all payors currently eligible to claim a provider's contracted rate due to the provider's and payor's respective written agreements with any contracting agent.

(5) Allow providers, upon the initial signing, renewal, or amendment of a provider contract, to decline to be included in any list of contracted providers that is sold, leased, transferred, or conveyed to payors that do not actively encourage the payors' beneficiaries to use the list of contracted providers when obtaining medical care as described in paragraph (2). Each provider's election under this paragraph shall be binding on the contracting agent with which the provider has the contract and on any other contracting agent that buys, leases, or otherwise obtains the list of contracted providers. A provider shall not be excluded from any list of contracted providers that is sold, leased, transferred, or conveyed to payors that actively encourage the

payors' beneficiaries to use the list of contracted providers when obtaining medical care, based upon the provider's refusal to be included on any list of contracted providers that is sold, leased, transferred, or conveyed to payors that do not actively encourage the payors' beneficiaries to use the list of contracted providers when obtaining medical care.

(6) Nothing in this subdivision shall be construed to impose requirements or regulations upon payors, as defined in subparagraph (A) of paragraph (3) of subdivision (d).

(c) Beginning July 1, 2000, a payor, as defined in subparagraph (B) of paragraph (3) of subdivision (d), shall do all of the following:

(1) Provide an explanation of benefits or explanation of review that identifies the name of the plan or network that has a written agreement signed by the provider whereby the payor is entitled, directly or indirectly, to pay a preferred rate for the services rendered.

(2) Demonstrate that it is entitled to pay a contracted rate within 30 business days of receipt of a written request from a provider who has received a claim payment from the payor. The failure of a payor to make the demonstration within 30 business days shall render the payor responsible for the amount that the payor would have been required to pay pursuant to the contract between the payor and the beneficiary, which amount shall be due and payable within 10 business days of receipt of written notice from the provider, and shall bar the payor from taking any future discounts from that provider without the provider's express written consent until the payor can demonstrate to the provider that it is entitled to pay a contracted rate as provided in this paragraph. A payor shall be deemed to have demonstrated that it is entitled to pay a contracted rate if it complies with either of the following:

(A) Discloses the name of the network that has a written agreement with the provider whereby the provider agrees to accept discounted rates, and describes the specific practices the payor utilizes to comply with paragraph (2) of subdivision (b).

(B) Identifies the provider's written agreement with a contracting agent whereby the provider agrees to be included on lists of contracted providers sold, leased, transferred, or conveyed to payors that do not actively encourage beneficiaries to use the

list of contracted providers pursuant to paragraph (5) of subdivision (b).

(d) For the purposes of this section, the following terms have the following meanings:

(1) "Beneficiary" means:

(A) For workers' compensation insurance, an employee seeking health care services for a work-related injury.

(B) For automobile insurance, those persons covered under the medical payments portion of the insurance contract.

(C) For group or individual health services covered through a health care service plan contract, including a specialized health care service plan contract, or a policy of disability insurance that covers hospital, medical, or surgical benefits, a subscriber, an enrollee, a policyholder, or an insured.

(2) "Contracting agent" means a third-party administrator or trust not licensed under the Health and Safety Code, the Insurance Code, or the Labor Code, a self-insured employer, a preferred provider organization, or an independent practice association, while engaged, for monetary or other consideration, in the act of selling, leasing, transferring, assigning, or conveying, a provider or provider panel to provide health care services to beneficiaries. For purposes of this section, a contracting agent shall not include a health care service plan, including a specialized health care service plan, an insurer licensed under the Insurance Code to provide disability insurance that covers hospital, medical, or surgical benefits, automobile insurance, or workers' compensation insurance, or a self-insured employer.

(3) (A) For purposes of subdivision (b), "payor" means a health care service plan, including a specialized health care service plan, an insurer licensed under the Insurance Code to provide disability insurance that covers hospital, medical, or surgical benefits, automobile insurance, workers' compensation insurance, or a self-insured employer that is responsible to pay for health care services provided to beneficiaries.

(B) For purposes of subdivision (c), "payor" means only those entities that provide coverage for hospital, medical, or surgical benefits that are not regulated under the Health and Safety Code, the Insurance Code, or the Labor Code.

(4) "Payor summary" means a written summary that includes the payor's name and the type of plan, including, but not limited to, a group health plan, an automobile insurance plan, and a workers' compensation insurance plan.

(5) "Provider" means any of the following:

(A) Any person licensed or certified pursuant to this division.

(B) Any person licensed pursuant to the Chiropractic Initiative Act or the Osteopathic Initiative Act.

(C) Any person licensed pursuant to Chapter 2.5 (commencing with Section 1440) of Division 2 of the Health and Safety Code.

(D) A clinic, health dispensary, or health facility licensed pursuant to Division 2 (commencing with Section 1200) of the Health and Safety Code.

(E) Any entity exempt from licensure pursuant to Section 1206 of the Health and Safety Code.

(e) This section shall become ~~operative on July 1, 2000~~ *inoperative on July 1, 2006, and as of January 1, 2007, is repealed, unless a later enacted statute that is enacted before January 1, 2007, deletes or extends the dates on which it becomes inoperative and is repealed.*

SEC. 3. Section 511.1 is added to the Business and Professions Code, to read:

511.1. (a) In order to ensure that providers are able to deliver high quality care to their patients and are able to manage their practices and to ensure that fair business practices are in place to provide a more competitive and properly functioning health care delivery system, it is the intent of the Legislature to prevent the unfair selling, leasing, or transferring of a health care provider's contract. It is further the intent of the Legislature that no health care provider shall be paid a discounted rate for health care services based on that provider's participation in a network or panel unless and until the health care provider has voluntarily agreed in writing, in advance, to the discount with respect to each payor that claims it.

(b) Beginning July 1, 2006, no contracting agent may sell, lease, assign, transfer, or convey its list of contracted health care providers and their contracted reimbursement rates to another payor, as defined in paragraph (5) of subdivision (g), and any such transaction shall be void, unlawful, and unenforceable unless all of the following conditions are met:

(1) The contracting agent has a direct contract signed by the provider that meets all of the following requirements:

(A) Contains model language adopted by the Department of Insurance and the Department of Managed Health Care through emergency regulations setting forth the rights of the provider under this section.

(B) Applies only to a single, as opposed to materially different, product or line of business and discloses the complete fee schedule applicable to that product or line of business.

(C) Only authorizes the sale, lease, transfer, assignment or conveyance of the provider's name and contracted rates to the extent that the provider specifically exercises the option affirmatively in writing to allow his or her name and contracted reimbursement rates to be included on the list of contracted providers that may be sold, leased, transferred, or conveyed to that payor. The written affirmative option to be exercised pursuant to this section shall only be accomplished through a separate document, on the payor summary, or in a separate section in the contract itself, within a box outlined in black, and shall be in a format that enables the provider to affirmatively opt in writing, for each potential payor, whether the provider's name and contracted rate may be sold, leased, transferred, or conveyed to that payor through check marks or any other clearly identifiable mechanism. To be an effective authorization, the separate section, document, or payor summary shall be signed by the provider. The provider's signature on the contract as a whole does not satisfy this requirement.

(D) Discloses what specific practices, if any, payors utilize to actively encourage a payor's beneficiaries to use the list of contracted providers when obtaining medical care that entitles a payor to claim a contracted rate.

(E) Clearly discloses whether the contracting agent intends to sell, transfer, lease, assign, or convey the list of contracted providers to any payor that does not actively encourage the payor's beneficiaries to use the list of contracted providers when obtaining medical care. Nothing in this subdivision shall be construed to require a payor to actively encourage the payor's beneficiaries to use the list of contracted providers when obtaining medical care in the case of an emergency.

(F) Allows the provider to terminate his or her authorization with respect to each payor that has access to the provider's name and contracted reimbursement rate on 30 days' written notice.

(G) Discloses all benefits and services the contracting agent will provide to both the provider and the payor.

(H) Discloses any fees or other remuneration the contracting agent may receive as a result of the sale, lease, assignment, transfer or conveyance of the list of contracted health care providers.

(2) A contracting agent that obtains a provider's power of attorney shall not transfer that power of attorney to another contracting agent.

(3) The contracting agent discloses, prior to the initial signing of the contract, a payor summary of all payors that seek to be eligible to claim a provider's contracted rate if the provider affirmatively opts in its written agreement with the contracting agent to allow his or her name and contracted reimbursement rate to be sold, leased, transferred, or conveyed to that payor.

(4) The contracting agent discloses the provider's current payor summary at least annually, and within 30 calendar days of receipt of a written request from a provider.

(5) The contracting agent discloses by registered or certified mail a payor summary of any additional payors that seek to be eligible to claim a provider's contracted rate due to the provider's written agreement with the contracting agent.

(6) The contracting agent does not transfer, sell, assign, lease, or convey the list of contracted providers to any entity that is not a payor, or include on the list any provider that has not affirmatively agreed in writing to specifically authorize that payor to have access to the provider's name and contracted reimbursement rate.

(7) The contracting agent does not allow the payor to transfer, sell, assign, lease or convey the list of contracted providers to any other payor or entity.

(8) The contracting agent requires those payors that are eligible to claim a provider's contracted rate to cease claiming entitlement to that rate upon termination of the provider's underlying contract or termination of the provider's authorization to allow that payor to continue to have access to the provider's name and contracted reimbursement rate.

(9) The contracting agent provides to a payor, upon the payor's request where its entitlement to a discount is being challenged, a copy of the agreement whereby the provider affirmatively agreed in writing to specifically authorize that payor to have access to that provider's name and contracted reimbursement rate.

(10) The activity does not violate any other provision of law.

(11) The contracting agent may only receive access fees or other remuneration for the sale, lease, transfer, or conveyance of a provider's name and contracted rate as long as the list of contracted providers is sold, transferred, leased, or conveyed to a payor that actively encourages a payor's beneficiaries to use the list of contracted providers when obtaining medical care.

(c) A provider shall be free to allow or decline the sale, leasing, transfer, or conveyance of the provider's name and contracted reimbursement rate with respect to each potential payor without penalty, sanction, or retaliation of any kind, including exclusion from the contracting agent's network.

(d) No payor shall be eligible to claim a provider's contracted rate unless the payor's name has been identified on the payor summary provided by the contracting agent and the provider has affirmatively opted in writing to allow that payor to use that rate.

(e) Beginning July 1, 2006, a payor, as defined in paragraph (5) of subdivision (g), that claims eligibility to a provider's contracted rate shall do both of the following:

(1) Include on the explanation of benefits, remittance advice, and any other explanation of review, the identity of the contracting agent through which the discount is claimed, as well as the names and telephone numbers of the individual or unit responsible for provider contracting for the contracting agent identified on the patient's insurance card that has a written agreement signed by the provider who submitted the claim whereby the payor is directly entitled to pay a preferred rate for the services rendered.

(2) Demonstrate that it is entitled to pay a contracted rate within 30 business days of receipt of a written request from a provider who has received a claim payment from the payor. A payor can initially determine such entitlement where it provides all of the following:

(A) Documentation of the name of the contracting agent and telephone number of the individual or unit responsible for provider contracting that has the written agreement signed by the provider whereby the provider affirmatively opted to accept discounted rates from the payor in question to be furnished to that provider.

(B) Documentation that the contract was not sold, leased, transferred, assigned, or conveyed to a payor for a product or business line that is materially different from that to which the underlying contract applies as it relates to increased workload or other responsibilities imposed or as it relates to decreased benefits conferred on the provider.

(C) Documentation that the patient to whom the services were provided was covered by the product or business line with respect to which the provider agreed to authorize discounts.

(D) Documentation that the patient was covered by an entity authorized to claim a discount.

(E) Documentation that the underlying contract is with a provider that has the same tax or employer identification number as that of the provider's practice that submitted the claim at issue. The failure of a payor to make the demonstration within 30 business days shall render the payor responsible for the amount that the payor would have been required to pay pursuant to the contract between the payor and the beneficiary, which shall be due and payable within 10 business days of receipt of written notice from the provider, and shall bar the payor from taking any future discounts from that provider without the provider's express written consent until the payor can demonstrate to the provider that it is entitled to pay a contracted rate as provided in this paragraph.

(f) A payor's initial determination that it is entitled to pay a contracted rate is deemed refuted where the provider provides any of the following:

(1) Documentation that the provider opted not to be on the list of contracted providers at issue.

(2) Documentation that the provider terminated the underlying contract.

(3) Documentation that the contract was sold, leased, transferred, assigned, or conveyed to a payor for a product or business line that is materially different from that to which the

underlying contract applies as it relates to increased workload or other responsibilities imposed or as it relates to decreased benefits conferred on the provider.

(4) Documentation that the patient was not covered by an entity authorized to claim a discount.

(5) Documentation that the underlying contract is with a provider that has a different tax or employer identification number than that of the provider's practice that submitted the claim at issue.

(g) For the purposes of this section, the following terms have the following meanings:

(1) "Actively encouraged its beneficiaries to use the list of contracted providers" means that either of the following requirements are met:

(A) The payor's contract with subscribers or insureds offers beneficiaries direct financial incentives to use the list of contracted providers when obtaining medical care. "Financial incentives" means reduced copayments, reduced deductibles, premium discounts directly attributable to the use of a provider panel, or financial penalties directly attributable to the nonuse of a provider panel.

(B) The payor provides information directly to its beneficiaries advising them of the existence of the list of contracted providers through the use of a variety of advertising or marketing approaches that supply the names, addresses, and telephone numbers of contracted providers to beneficiaries in advance of their selection of a health care provider, which approaches may include, but are not limited to, the use of provider directories, or the use of toll-free telephone numbers or Internet Web site addresses supplied directly to every beneficiary. However, Internet Web site addresses alone shall not be deemed to satisfy the requirements of this subparagraph. Nothing in this subparagraph shall prevent contracting agents or payors from providing only listings of providers located within a reasonable geographic range of a beneficiary.

(2) "Beneficiary" means the following:

(A) For workers' compensation insurance, an employee seeking health care services for a work-related injury.

(B) For automobile insurance, those persons covered under the medical payments portion of the insurance contract.

(C) For group or individual health services covered through a health care service plan contract including a specialized health care service plan contract or a policy of disability insurance that covers hospital, medical, or surgical benefits, a subscriber, an enrollee, a policyholder, or an insured.

(3) "Contracting agent" means a third-party administrator or trust not licensed under the Health and Safety Code, the Insurance Code, or the Labor Code, a self-insured employer, a preferred provider organization, an independent practice association, or any other entity while engaged, for monetary or other consideration, in the act of selling, leasing, transferring, assigning, or conveying a provider or provider panel to provide health care services to beneficiaries. For purposes of this section, a contracting agent shall not include a health care service plan, including a specialized health care service plan, an insurer licensed under the Insurance Code to provide disability insurance that covers hospital, medical, or surgical benefits, automobile insurance, or workers' compensation insurance, or a self-insured employer. A contracting agent shall not include either of the following:

(A) A group of health care providers organized as a partnership or professional corporation that contracts with only one health care service plan to provide or arrange for the provision of health care services to that plan's members.

(B) A hospital corporation that has an identical board of directors with a health plan that exclusively contracts with the group of providers described in subparagraph (A) to provide professional medical services to its enrollees.

(4) "Materially different" means a network, product, or business line that a reasonable provider would attach importance to in determining whether to participate in it, including, but not limited to, in addition to the fee schedule amount, the types of services to be provided, claims processing rules, utilization review procedures, and patient collection processes.

(5) "Payor" means a health care service plan, including a specialized health care service plan, an insurer licensed under the Insurance Code to provide disability insurance that covers hospital, medical, or surgical benefits, automobile insurance, workers' compensation insurance, or a self-insured employer

that is responsible to pay for health care services provided to beneficiaries. "Payor" also means only those entities that provide coverage for hospital, medical, or surgical benefits that are not regulated under the Health and Safety Code, the Insurance Code, or the Labor Code.

(6) "Payor summary" means a written summary that includes the payor's name, the type of plan, including, but not limited to, a group health plan, an automobile insurance plan, and a workers' compensation insurance plan, and the specific practices, if any, the payor utilizes to actively encourage a payor's beneficiaries to use the list of contracted providers when obtaining medical care and the identity and telephone number for the individual or office responsible for handling provider reimbursement. The payor summary shall clearly identify each payor that does not actively encourage its beneficiaries to do so. The payor summary shall be set forth within a box outlined in black and in a format that provides the opportunity for the provider to affirmatively opt in writing to allow or decline the sale, transfer, lease, or conveyance of the provider's name and contracted rates with respect to each payor on the summary, through check marks or any other clearly identifiable mechanism, and, to the extent the provider has already made this election, clearly discloses each such election that the provider has made. The payor summary shall be signed by the provider.

(7) "Provider" means any of the following:

(A) A person licensed or certified pursuant to this division.

(B) A person licensed pursuant to the Chiropractic Initiative Act or the Osteopathic Initiative Act.

(C) A person licensed pursuant to Chapter 2.5 (commencing with Section 1440) of Division 2 of the Health and Safety Code.

(D) A clinic, health dispensary, or health facility licensed pursuant to Division 2 (commencing with Section 1200) of the Health and Safety Code.

(E) Any entity exempt from licensure pursuant to Section 1206 of the Health and Safety Code.

(h) This section shall become operative July 1, 2006.

SEC. 4. Section 511.3 of the Business and Professions Code is amended to read:

511.3. (a) When a contracting agent sells, leases, or transfers a health provider's contract to a payor, the rights and obligations

of the provider shall be governed by the underlying contract between the health care provider and the contracting agent.

(b) *Notwithstanding any other provision of law, the underlying contract shall not obligate a provider to participate in materially different networks, products, or business lines, nor authorize, or otherwise require the provider to consent to the sale, lease, transfer, assignment, or conveyance of the contracted list of providers to any network, product, or business line that is materially different from that to which the underlying contract applies, either as it relates to increased workload or other responsibilities imposed on the provider or as it relates to any decreased benefits conferred on the provider. "Materially different," for the purposes of this section, means a network, product, or business line that a reasonable provider would attach importance to in determining whether to participate in it, including, but not limited to, the fee schedule amount, the types of services to be provided, claims processing and payment rules, utilization review procedures, and patient collection processes.*

(c) For purposes of this section, the following terms shall have the following meanings:

(1) "Contracting agent" has the meaning set forth in ~~paragraph (2) of subdivision (d) of~~ Section 511.1.

(2) "Payor" has the meaning set forth in ~~paragraph (3) of subdivision (d) of~~ Section 511.1.

SEC. 5. Section 1375.7 of the Health and Safety Code is amended to read:

1375.7. (a) This section shall be known and may be cited as the Health Care Providers' Bill of Rights.

(b) No contract issued, amended, or renewed on or after January 1, 2003, between a plan and a health care provider for the provision of health care services to a plan enrollee or subscriber shall contain any of the following terms:

(1) (A) Authority for the plan to change a material term of the contract, unless the change has first been negotiated and agreed to by the provider and the plan or the change is necessary to comply with state or federal law or regulations or any accreditation requirements of a private sector accreditation organization. If a change is made by amending a manual, policy, or procedure document referenced in the contract, the plan shall provide 45 business days' notice to the provider, and the provider

has the right to negotiate and agree to the change. If the plan and the provider cannot agree to the change to a manual, policy, or procedure document, the provider has the right to terminate the contract prior to the implementation of the change. In any event, the plan shall provide at least 45 business days' notice of its intent to change a material term, unless a change in state or federal law or regulations or any accreditation requirements of a private sector accreditation organization requires a shorter timeframe for compliance. However, if the parties mutually agree, the 45-business day notice requirement may be waived. Nothing in this subparagraph limits the ability of the parties to mutually agree to the proposed change at any time after the provider has received notice of the proposed change.

(B) If a contract between a provider and a plan provides benefits to enrollees or subscribers through a preferred provider arrangement, the contract may contain provisions permitting a material change to the contract by the plan if the plan provides at least 45 business days' notice to the provider of the change and the provider has the right to terminate the contract prior to the implementation of the change.

(C) If a contract between a noninstitutional provider and a plan provides benefits to enrollees or subscribers covered under the Medi-Cal or Healthy Families program and compensates the provider on a fee-for-service basis, the contract may contain provisions permitting a material change to the contract by the plan, if the following requirements are met:

(i) The plan gives the provider a minimum of 90 business days' notice of its intent to change a material term of the contract.

(ii) The plan clearly gives the provider the right to exercise his or her intent to negotiate and agree to the change within 30 business days of the provider's receipt of the notice described in clause (i).

(iii) The plan clearly gives the provider the right to terminate the contract within 90 business days from the date of the provider's receipt of the notice described in clause (i) if the provider does not exercise the right to negotiate the change or no agreement is reached, as described in clause (ii).

(iv) The material change becomes effective 90 business days from the date of the notice described in clause (i) if the provider

does not exercise his or her right to negotiate the change, as described in clause (ii), or to terminate the contract, as described in clause (iii).

(2) A provision that requires a health care provider to accept additional patients beyond the contracted number or in the absence of a number if, in the reasonable professional judgment of the provider, accepting additional patients would endanger patients' access to, or continuity of, care.

(3) A requirement to comply with quality improvement or utilization management programs or procedures of a plan, unless the requirement is fully disclosed to the health care provider at least 15 business days prior to the provider executing the contract. However, the plan may make a change to the quality improvement or utilization management programs or procedures at any time if the change is necessary to comply with state or federal law or regulations or any accreditation requirements of a private sector accreditation organization. A change to the quality improvement or utilization management programs or procedures shall be made pursuant to paragraph (1).

(4) A provision that waives or conflicts with any provision of this chapter. A provision in the contract that allows the plan to provide professional liability or other coverage or to assume the cost of defending the provider in an action relating to professional liability or other action is not in conflict with, or in violation of, this chapter.

(5) A requirement to permit access to patient information in violation of federal or state laws concerning the confidentiality of patient information.

(c) (1) When a contracting agent sells, leases, or transfers a health provider's contract to a payor, the rights and obligations of the provider shall be governed by the underlying contract between the health care provider and the contracting agent.

(2) *Notwithstanding any other provision of law, the underlying contract shall not obligate a provider to participate in materially different networks, products, or business lines, nor authorize, or otherwise require the provider to consent to the sale, lease, transfer, assignment, or conveyance of the contracted list of providers to any network, product, or business line that is materially different from that to which the underlying contract applies, either as it relates to increased workload or other*

responsibilities imposed on the provider or as it relates to any decreased benefits conferred on the provider. "Materially different," for the purposes of this section, means a network, product, or business line that a reasonable provider would attach importance to in determining whether to participate in it, including, but not limited to, the fee schedule amount, the types of services to be provided, claims processing and payment rules, utilization review procedures, and patient collection processes.

(3) For purposes of this subdivision, the following terms shall have the following meanings:

(A) "Contracting agent" has the meaning set forth in ~~paragraph (2) of subdivision (d) of~~ Section 1395.6.

(B) "Payor" has the meaning set forth in ~~paragraph (3) of subdivision (d) of~~ Section 1395.6.

(d) Any contract provision that violates subdivision (b) or (c) shall be void, unlawful, and unenforceable.

(e) The department shall compile the information submitted by plans pursuant to subdivision (h) of Section 1367 into a report and submit the report to the Governor and the Legislature by March 15 of each calendar year.

(f) Nothing in this section shall be construed or applied as setting the rate of payment to be included in contracts between plans and health care providers.

(g) For purposes of this section the following definitions apply:

(1) "Health care provider" means any professional person, medical group, independent practice association, organization, health care facility, or other person or institution licensed or authorized by the state to deliver or furnish health services.

(2) "Material" means a provision in a contract to which a reasonable person would attach importance in determining the action to be taken upon the provision.

SEC. 6. Section 1395.6 of the Health and Safety Code is amended to read:

1395.6. (a) In order to prevent the improper selling, leasing, or transferring of a health care provider's contract, it is the intent of the Legislature that every arrangement that results in a payor paying a health care provider a reduced rate for health care services based on the health care provider's participation in a network or panel shall be disclosed to the provider in advance

and that the payor shall actively encourage beneficiaries to use the network, unless the health care provider agrees to provide discounts without that active encouragement.

(b) Beginning July 1, 2000, every contracting agent that sells, leases, assigns, transfers, or conveys its list of contracted health care providers and their contracted reimbursement rates to a payor, as defined in subparagraph (A) of paragraph (3) of subdivision (d), or another contracting agent shall, upon entering or renewing a provider contract, do all of the following:

(1) Disclose to the provider whether the list of contracted providers may be sold, leased, transferred, or conveyed to other payors or other contracting agents, and specify whether those payors or contracting agents include workers' compensation insurers or automobile insurers.

(2) Disclose what specific practices, if any, payors utilize to actively encourage a payor's beneficiaries to use the list of contracted providers when obtaining medical care that entitles a payor to claim a contracted rate. For purposes of this paragraph, a payor is deemed to have actively encouraged its beneficiaries to use the list of contracted providers if one of the following occurs:

(A) The payor's contract with subscribers or insureds offers beneficiaries direct financial incentives to use the list of contracted providers when obtaining medical care. "Financial incentives" means reduced copayments, reduced deductibles, premium discounts directly attributable to the use of a provider panel, or financial penalties directly attributable to the nonuse of a provider panel.

(B) The payor provides information to its beneficiaries, who are parties to the contract, or, in the case of workers' compensation insurance, the employer, advising them of the existence of the list of contracted providers through the use of a variety of advertising or marketing approaches that supply the names, addresses, and telephone numbers of contracted providers to beneficiaries in advance of their selection of a health care provider, which approaches may include, but are not limited to, the use of provider directories, or the use of toll-free telephone numbers or Internet web site addresses supplied directly to every beneficiary. However, internet web site addresses alone shall not be deemed to satisfy the requirements of this subparagraph. Nothing in this subparagraph shall prevent contracting agents or

payors from providing only listings of providers located within a reasonable geographic range of a beneficiary.

(3) Disclose whether payors to which the list of contracted providers may be sold, leased, transferred, or conveyed may be permitted to pay a provider's contracted rate without actively encouraging the payors' beneficiaries to use the list of contracted providers when obtaining medical care. Nothing in this subdivision shall be construed to require a payor to actively encourage the payor's beneficiaries to use the list of contracted providers when obtaining medical care in the case of an emergency.

(4) Disclose, upon the initial signing of a contract, and within 30 calendar days of receipt of a written request from a provider or provider panel, a payor summary of all payors currently eligible to claim a provider's contracted rate due to the provider's and payor's respective written agreement with any contracting agent.

(5) Allow providers, upon the initial signing, renewal, or amendment of a provider contract, to decline to be included in any list of contracted providers that is sold, leased, transferred, or conveyed to payors that do not actively encourage the payors' beneficiaries to use the list of contracted providers when obtaining medical care as described in paragraph (2). Each provider's election under this paragraph shall be binding on the contracting agent with which the provider has the contract and any contracting agent that buys, leases, or otherwise obtains the list of contracted providers. A provider shall not be excluded from any list of contracted providers that is sold, leased, transferred, or conveyed to payors that actively encourage the payors' beneficiaries to use the list of contracted providers when obtaining medical care, based upon the provider's refusal to be included on any list of contracted providers that is sold, leased, transferred, or conveyed to payors that do not actively encourage the payors' beneficiaries to use the list of contracted providers when obtaining medical care.

(6) Nothing in this subdivision shall be construed to impose requirements or regulations upon payors, as defined in subparagraph (A) of paragraph (3) of subdivision (d).

(c) Beginning July 1, 2000, a payor, as defined in subparagraph (B) of paragraph (3) of subdivision (d), shall do all of the following:

(1) Provide an explanation of benefits or explanation of review that identifies the name of the network that has a written agreement signed by the provider whereby the payor is entitled, directly or indirectly, to pay a preferred rate for the services rendered.

(2) Demonstrate that it is entitled to pay a contracted rate within 30 business days of receipt of a written request from a provider who has received a claim payment from the payor. The failure of a payor to make the demonstration within 30 business days shall render the payor responsible for the amount that the payor would have been required to pay pursuant to the applicable health care service plan contract, including a specialized health care service plan contract, covering the beneficiary, which amount shall be due and payable within 10 business days of receipt of written notice from the provider, and shall bar the payor from taking any future discounts from that provider without the provider's express written consent until the payor can demonstrate to the provider that it is entitled to pay a contracted rate as provided in this paragraph. A payor shall be deemed to have demonstrated that it is entitled to pay a contracted rate if it complies with either of the following:

(A) Discloses the name of the network that has a written agreement with the provider whereby the provider agrees to accept discounted rates, and describes the specific practices the payor utilizes to comply with paragraph (2) of subdivision (b).

(B) Identifies the provider's written agreement with a contracting agent whereby the provider agrees to be included on lists of contracted providers sold, leased, transferred, or conveyed to payors that do not actively encourage beneficiaries to use the list of contracted providers pursuant to paragraph (5) of subdivision (b).

(d) For the purposes of this section, the following terms have the following meanings:

(1) "Beneficiary" means:

(A) For workers' compensation insurance, an employee seeking health care services for a work-related injury.

(B) For automobile insurance, those persons covered under the medical payments portion of the insurance contract.

(C) For group or individual health services covered through a health care service plan contract, including a specialized health care service plan contract, or a policy of disability insurance that covers hospital, medical, or surgical benefits, a subscriber, an enrollee, a policyholder, or an insured.

(2) "Contracting agent" means a health care service plan, including a specialized health care service plan, while engaged, for monetary or other consideration, in the act of selling, leasing, transferring, assigning, or conveying, a provider or provider panel to payors to provide health care services to beneficiaries.

(3) (A) For the purposes of subdivision (b), "payor" means a health care service plan, including a specialized health care service plan, an insurer licensed under the Insurance Code to provide disability insurance that covers hospital, medical, or surgical benefits, automobile insurance, workers' compensation insurance, or a self-insured employer that is responsible to pay for health care services provided to beneficiaries.

(B) For the purposes of subdivision (c), "payor" means only a health care service plan, including a specialized health care service plan that has purchased, leased, or otherwise obtained the use of a provider or provider panel to provide health care services to beneficiaries pursuant to a contract that authorizes payment at discounted rates.

(4) "Payor summary" means a written summary that includes the payor's name and the type of plan, including, but not limited to, a group health plan, an automobile insurance plan, and a workers' compensation insurance plan.

(5) "Provider" means any of the following:

(A) Any person licensed or certified pursuant to Division 2 (commencing with Section 500) of the Business and Professions Code.

(B) Any person licensed pursuant to the Chiropractic Initiative Act or the Osteopathic Initiative Act.

(C) Any person licensed pursuant to Chapter 2.5 (commencing with Section 1440) of Division 2.

(D) A clinic, health dispensary, or health facility licensed pursuant to Division 2 (commencing with Section 1200).

(E) Any entity exempt from licensure pursuant to Section 1206.

(e) This section shall become ~~operative on July 1, 2000~~ *inoperative on July 1, 2006, and, as of January 1, 2007, is repealed, unless a later enacted statute that is enacted before January 1, 2007, deletes or extends the dates on which it becomes inoperative and is repealed*.

SEC. 7. Section 1395.6 is added to the Health and Safety Code, to read:

1395.6. (a) In order to ensure that providers are able to deliver high quality care to their patients and are able to manage their practices and that fair business practices are in place to provide a more competitive and properly functioning health care delivery system, it is the intent of the Legislature to prevent the unfair selling, leasing, or transferring of a health care provider's contract. It is further the intent of the Legislature that no health care provider shall be paid a discounted rate for health care services based on that provider's participation in a network or panel unless and until the health care provider has voluntarily agreed in writing, in advance, to the discount with respect to each payor that claims it.

(b) Beginning July 1, 2006, no contracting agent may sell, lease, assign, transfer, or convey its list of contracted health care providers and their contracted reimbursement rates to another payor, as defined in paragraph (5) of subdivision (g), and any such transaction shall be void, unlawful and unenforceable unless all of the following conditions are met:

(1) The contracting agent has a direct contract signed by the provider that meets all of the following requirements:

(A) Contains model language adopted by the Department of Insurance and the Department of Managed Health Care through emergency regulations setting forth the rights of the provider under this section.

(B) Applies only to a single, as opposed to materially different, product or line of business, and discloses the complete fee schedule applicable to that product or line of business.

(C) Only authorizes the sale, lease, transfer, assignment or conveyance of the provider's name and contracted rates to the extent the provider specifically exercises the option affirmatively in writing to allow his or her name and contracted

reimbursement rates to be included on the list of contracted providers that may be sold, leased, transferred, or conveyed to that payor. The written affirmative option to be exercised pursuant to this section shall only be accomplished through a separate document, on the payor summary, or in a separate section in the contract itself, within a box outlined in black, and in a format that enables the provider to affirmatively opt in writing, for each potential payor, whether the provider's name and contracted rate may be sold, leased, transferred or conveyed to that payor through check marks or any other clearly identifiable mechanism. To be an effective authorization, the separate section, document, or payor summary shall be signed by the provider. The provider's signature on the contract as a whole does not satisfy this requirement.

(D) Discloses what specific practices, if any, payors utilize to actively encourage a payor's beneficiaries to use the list of contracted providers when obtaining medical care that entitles a payor to claim a contracted rate.

(E) Clearly discloses whether the contracting agent intends to sell, transfer, lease, assign, or convey the list of contracted providers to any payor that does not actively encourage a payor's beneficiaries to use the list of contracted providers when obtaining medical care. Nothing in this subdivision shall be construed to require a payor to actively encourage the payor's beneficiaries to use the list of contracted providers when obtaining medical care in the case of an emergency.

(F) Allows the provider to terminate his or her authorization with respect to each payor that has access to the provider's name and contracted reimbursement rate on 30 days' written notice.

(G) Discloses all benefits and services the contracting agent will provide to both the provider and payor.

(H) Discloses any fees or other remuneration the contracting agent may receive as a result of the sale, lease, assignment, transfer or conveyance of the list of contracted health care providers.

(2) A contracting agent that obtains a provider's power of attorney shall not transfer that power of attorney to another contracting agent.

(3) The contracting agent discloses, prior to the initial signing of the contract, a payor summary of all payors that seek to be

eligible to claim a provider's contracted rate if the provider affirmatively opts in its written agreement with the contracting agent to allow his or her name and contracted reimbursement rate to be sold, leased, transferred, or conveyed to that payor.

(4) The contracting agent discloses the provider's current payor summary at least annually, and within 30 calendar days of receipt of a written request from a provider.

(5) The contracting agent discloses by registered or certified mail a payor summary of any additional payors that seek to be eligible to claim a provider's contracted rate due to the provider's written agreement with the contracting agent.

(6) The contracting agent does not transfer, sell, assign, lease, or convey the list of contracted providers to any entity that is not a payor, or include on the list any provider that has not affirmatively agreed in writing to specifically authorize that payor to have access to the provider's name and contracted reimbursement rate.

(7) The contracting agent does not allow the payor to transfer, sell, assign, lease or convey the list of contracted providers to any other payor or entity.

(8) The contracting agent requires those payors that are eligible to claim a provider's contracted rate to cease claiming entitlement to that rate upon termination of the provider's underlying contract, or termination of the provider's authorization to allow that payor to continue to have access to the provider's name and contracted reimbursement rate.

(9) The contracting agent provides to the payor, upon a payor's request where its entitlement to a discount is being challenged, a copy of the agreement whereby the provider affirmatively agreed in writing to specifically authorize that payor to have access to that provider's name and contracted reimbursement rate.

(10) The activity does not violate any other provision of law.

(11) The contracting agent may only receive access fees or other remuneration for the sale, lease, transfer, or conveyance of a provider's name and contracted rate as long as the list of contracted providers is sold, transferred, leased, or conveyed to a payor that actively encourages a payor's beneficiaries to use the list of contracted providers when obtaining medical care.

(c) A provider shall be free to allow or decline the sale, leasing, transfer, or conveyance of the provider's name and contracted reimbursement rate with respect to each potential payor without penalty, sanction, or retaliation of any kind, including exclusion from the contracting agent's network.

(d) No payor shall be eligible to claim a provider's contracted rate unless the payor's name has been identified on the payor summary provided by the contracting agent and the provider has affirmatively opted in writing to allow that payor to use that rate.

(e) Beginning July 1, 2006, a payor, as defined in paragraph (5) of subdivision (g), that claims eligibility to a provider's contracted rate shall do both of the following:

(1) Include on the explanation of benefits, remittance advice, and any other explanation of review the identity of the contracting agent through which the discount is claimed, as well as the names and telephone numbers of the individual or unit responsible for provider contracting for the contracting agent identified on the patient's insurance card that has a written agreement signed by the provider who submitted the claim whereby the payor is directly entitled to pay a preferred rate for the services rendered.

(2) Demonstrate that it is entitled to pay a contracted rate within 30 business days of receipt of a written request from a provider who has received a claim payment from the payor. A payor can initially determine such entitlement where it provides all of the following:

(A) Documentation of the name of the contracting agent and telephone number of the individual or unit responsible for provider contracting that has the written agreement signed by the provider whereby the provider affirmatively opted to accept discounted rates from the payor in question to be furnished to that provider.

(B) Documentation that the contract was not sold, leased, transferred, assigned, or conveyed to a payor for a product or business line that is materially different from that to which the underlying contract applies as it relates to increased workload or other responsibilities imposed or as it relates to decreased benefits conferred on the provider.

(C) Documentation that the patient to whom the services were provided was covered by the product or business line with respect to which the provider agreed to authorize discounts.

(D) Documentation that the patient was covered by an entity authorized to claim a discount.

(E) Documentation that the underlying contract is with a provider that has the same tax or employer identification number as that of the provider's practice that submitted the claim at issue. The failure of a payor to make the demonstration within 30 business days shall render the payor responsible for the amount that the payor would have been required to pay pursuant to the contract between the payor and the beneficiary, which shall be due and payable within 10 business days of receipt of written notice from the provider, and shall bar the payor from taking any future discounts from that provider without the provider's express written consent until the payor can demonstrate to the provider that it is entitled to pay a contracted rate as provided in this paragraph.

(f) A payor's initial determination that it is entitled to pay a contracted rate is deemed refuted where the provider provides any of the following:

(1) Documentation that the provider opted not to be on the list of contracted providers at issue.

(2) Documentation that the provider terminated the underlying contract.

(3) Documentation that the contract was sold, leased, transferred, assigned or conveyed to a payor for a product or business line that is materially different from that to which the underlying contract applies as it relates to increased workload or other responsibilities imposed or as it relates to decreased benefits conferred on the provider.

(4) Documentation that the patient was not covered by an entity authorized to claim a discount.

(5) Documentation that the underlying contract is with a provider that has a different tax or employer identification number than that of the provider's practice that submitted the claim at issue.

(g) For the purposes of this section, the following terms have the following meanings:

(1) "Actively encouraged its beneficiaries to use the list of contracted providers" means either of the following requirements are met:

(A) The payor's contract with subscribers or insureds offers beneficiaries direct financial incentives to use the list of contracted providers when obtaining medical care. "Financial incentives" means reduced copayments, reduced deductibles, premium discounts directly attributable to the use of a provider panel, or financial penalties directly attributable to the nonuse of a provider panel.

(B) The payor provides information directly to its beneficiaries advising them of the existence of the list of contracted providers through the use of a variety of advertising or marketing approaches that supply the names, addresses, and telephone numbers of contracted providers to beneficiaries in advance of their selection of a health care provider, which approaches may include, but are not limited to, the use of provider directories, or the use of toll-free telephone numbers or Internet Web site addresses supplied directly to every beneficiary. However, Internet Web site addresses alone shall not be deemed to satisfy the requirements of this subparagraph. Nothing in this subparagraph shall prevent contracting agents or payors from providing only listings of providers located within a reasonable geographic range of a beneficiary.

(2) "Beneficiary" means the following:

(A) For workers' compensation insurance, an employee seeking health care services for a work-related injury.

(B) For automobile insurance, those persons covered under the medical payments portion of the insurance contract.

(C) For group or individual health services covered through a health care service plan contract including a specialized health care service plan contract, or a policy of disability insurance that covers hospital, medical, or surgical benefits, a subscriber, an enrollee, a policyholder, or an insured.

(3) "Contracting agent" means a health care service plan, including a specialized health care service plan, or any other entity while engaged, for monetary or other consideration, in the act of selling, leasing, transferring, assigning or conveying, a provider or provider panel to payors to provide health care

services to beneficiaries. A contracting agent shall not include either of the following:

(A) A group of health care providers organized as a partnership or professional corporation that contracts with only one health care service plan to provide or arrange for the provision of health care services to that plan's members.

(B) A hospital corporation that has an identical board of directors with a health plan that exclusively contracts with the group of providers described in subparagraph (A) to provide professional medical services to its enrollees.

(4) "Materially different" means a network, product, or business line that a reasonable provider would attach importance to in determining whether to participate in it, including, but not limited to, in addition to the fee schedule amount, the types of services to be provided, claims processing rules, utilization review procedures, and patient collection processes.

(5) "Payor" means a health care service plan, including a specialized health care service plan, an insurer licensed under the Insurance Code to provide disability insurance that covers hospital, medical, or surgical benefits, automobile insurance, workers' compensation insurance, or a self-insured employer that is responsible to pay for health care services provided to beneficiaries. "Payor" also means only those entities that provide coverage for hospital, medical, or surgical benefits that are not regulated under this code, the Insurance Code, or the Labor Code.

(6) "Payor summary" means a written summary that includes the payor's name, the type of plan, including, but not limited to, a group health plan, an automobile insurance plan, and a workers' compensation insurance plan, and the specific practices, if any, the payor utilizes to actively encourage a payor's beneficiaries to use the list of contracted providers when obtaining medical care and the identity and telephone number for the individual or office responsible for handling provider reimbursement. The payor summary shall clearly identify each payor that does not actively encourage its beneficiaries to do so. The payor summary must be set forth within a box outlined in black and in a format that provides the opportunity for the provider to affirmatively opt in writing to allow or decline the

sale, transfer, lease, or conveyance of the provider's name and contracted rates with respect to each payor on the summary, through check marks or any other clearly identifiable mechanism, and, to the extent the provider has already made this election, clearly discloses each such election that the provider has made. The payor summary shall be signed by the provider.

(7) "Provider" means any of the following:

(A) A person licensed or certified pursuant to this division.

(B) A person licensed pursuant to the Chiropractic Initiative Act or the Osteopathic Initiative Act.

(C) A person licensed pursuant to Chapter 2.5 (commencing with Section 1440) of Division 2 of the Health and Safety Code.

(D) A clinic, health dispensary, or health facility licensed pursuant to Division 2 (commencing with Section 1200) of the Health and Safety Code.

(E) Any entity exempt from licensure pursuant to Section 1206 of the Health and Safety Code.

(g) This section shall become operative July 1, 2006.

SEC. 8. Section 10178.3 of the Insurance Code is amended to read:

10178.3. (a) In order to prevent the improper selling, leasing, or transferring of a health care provider's contract, it is the intent of the Legislature that every arrangement that results in a payor paying a health care provider a reduced rate for health care services based on the health care provider's participation in a network or panel shall be disclosed to the provider in advance and that the payor shall actively encourage beneficiaries to use the network, unless the health care provider agrees to provide discounts without that active encouragement.

(b) Beginning July 1, 2000, every contracting agent that sells, leases, assigns, transfers, or conveys its list of contracted health care providers and their contracted reimbursement rates to a payor, as defined in subparagraph (A) of paragraph (3) of subdivision (d), or another contracting agent shall, upon entering or renewing a provider contract, do all of the following:

(1) Disclose whether the list of contracted providers may be sold, leased, transferred, or conveyed to other payors or other contracting agents, and specify whether those payors or contracting agents include workers' compensation insurers or automobile insurers.

(2) Disclose what specific practices, if any, payors utilize to actively encourage a payor's beneficiaries to use the list of contracted providers when obtaining medical care that entitles a payor to claim a contracted rate. For purposes of this paragraph, a payor is deemed to have actively encouraged its beneficiaries to use the list of contracted providers if one of the following occurs:

(A) The payor's contract with subscribers or insureds offers beneficiaries direct financial incentives to use the list of contracted providers when obtaining medical care. "Financial incentives" means reduced copayments, reduced deductibles, premium discounts directly attributable to the use of a provider panel, or financial penalties directly attributable to the nonuse of a provider panel.

(B) The payor provides information to its beneficiaries, who are parties to the contract, or, in the case of workers' compensation insurance, the employer, advising them of the existence of the list of contracted providers through the use of a variety of advertising or marketing approaches that supply the names, addresses, and telephone numbers of contracted providers to beneficiaries in advance of their selection of a health care provider, which approaches may include, but are not limited to, the use of provider directories, or the use of toll-free telephone numbers or Internet Web site addresses supplied directly to every beneficiary. However, Internet Web site addresses alone shall not be deemed to satisfy the requirements of this subparagraph. Nothing in this subparagraph shall prevent contracting agents or payors from providing only listings of providers located within a reasonable geographic range of a beneficiary.

(3) Disclose whether payors to which the list of contracted providers may be sold, leased, transferred, or conveyed may be permitted to pay a provider's contracted rate without actively encouraging the payors' beneficiaries to use the list of contracted providers when obtaining medical care. Nothing in this subdivision shall be construed to require a payor to actively encourage the payor's beneficiaries to use the list of contracted providers when obtaining medical care in the case of an emergency.

(4) Disclose, upon the initial signing of a contract, and within 30 calendar days of receipt of a written request from a provider or provider panel, a payor summary of all payors currently

eligible to claim a provider's contracted rate due to the provider's and payor's respective written agreements with any contracting agent.

(5) Allow providers, upon the initial signing, renewal, or amendment of a provider contract, to decline to be included in any list of contracted providers that is sold, leased, transferred, or conveyed to payors that do not actively encourage the payors' beneficiaries to use the list of contracted providers when obtaining medical care as described in paragraph (2). Each provider's election under this paragraph shall be binding on the contracting agent with which the provider has a contract and any other contracting agent that buys, leases, or otherwise obtains the list of contracted providers. A provider shall not be excluded from any list of contracted providers that is sold, leased, transferred, or conveyed to payors that actively encourage the payors' beneficiaries to use the list of contracted providers when obtaining medical care, based upon the provider's refusal to be included on any list of contracted providers that is sold, leased, transferred, or conveyed to payors that do not actively encourage the payors' beneficiaries to use the list of contracted providers when obtaining medical care.

(6) Nothing in this subdivision shall be construed to impose requirements or regulations upon payors, as defined in subparagraph (A) of paragraph (3) of subdivision (d).

(c) Beginning July 1, 2000, a payor, as defined in subparagraph (B) of paragraph (3) of subdivision (d), shall do ~~all~~ *both* of the following:

(1) Provide an explanation of benefits or explanation of review that identifies the name of the network that has a written agreement signed by the provider whereby the payor is entitled, directly or indirectly, to pay a preferred rate for the services rendered.

(2) Demonstrate that it is entitled to pay a contracted rate within 30 business days of receipt of a written request from a provider who has received a claim payment from the payor. The failure of a payor to make the demonstration within 30 business days shall render the payor responsible for the amount that the payor would have been required to pay pursuant to the beneficiary's policy with the payor, which amount shall be due and payable within 10 business days of receipt of written notice

from the provider, and shall bar the payor from taking any future discounts from that provider without the provider's express written consent until the payor can demonstrate to the provider that it is entitled to pay a contracted rate as provided in this subdivision. A payor shall be deemed to have demonstrated that it is entitled to pay a contracted rate if it ~~complies with~~ *does* either of the following:

(A) Discloses the name of the network that has a written agreement with the provider whereby the provider agrees to accept discounted rates, and describes the specific practices the payor utilizes to comply with paragraph (2) of subdivision (b).

(B) Identifies the provider's written agreement with a contracting agent whereby the provider agrees to be included on lists of contracted providers sold, leased, transferred, or conveyed to payors that do not actively encourage beneficiaries to use the list of contracted providers pursuant to paragraph (5) of subdivision (b).

(d) For the purposes of this section, the following terms have the following meanings:

(1) "Beneficiary" means *the following*:

(A) For automobile insurance, those persons covered under the medical payments portion of the insurance contract.

(B) For group or individual health services covered through a health care service plan contract, including a specialized health care service plan contract, or a policy of disability insurance that covers hospital, medical, or surgical benefits, a subscriber, an enrollee, a policyholder, or an insured.

(C) For workers' compensation insurance, an employee seeking health care services for a work-related injury.

(2) "Contracting agent" means an insurer licensed under this code to provide disability insurance that covers hospital, medical, or surgical benefits, automobile insurance, or workers' compensation insurance, while engaged, for monetary or other consideration, in the act of selling, leasing, transferring, assigning, or conveying a provider or provider panel to provide health care services to beneficiaries.

(3) (A) For the purposes of subdivision (b), "payor" means a health care service plan, including a specialized health care service plan, an insurer licensed under this code to provide disability insurance that covers hospital, medical, or surgical

benefits, automobile insurance, or workers' compensation insurance, or a self-insured employer that is responsible to pay for health care services provided to beneficiaries.

(B) For the purposes of subdivision (c), "payor" means only an insurer licensed under this code to provide disability insurance that covers hospital, medical, or surgical benefits, or automobile insurance, if that insurer is responsible to pay for health care services provided to beneficiaries.

(4) "Payor summary" means a written summary that includes the payor's name and the type of plan, including, but not limited to, a group health plan, an automobile insurance plan, and a workers' compensation insurance plan.

(5) "Provider" means any of the following:

(A) Any person licensed or certified pursuant to Division 2 (commencing with Section 500) of the Business and Professions Code.

(B) Any person licensed pursuant to the Chiropractic Initiative Act or the Osteopathic Initiative Act.

(C) Any person licensed pursuant to Chapter 2.5 (commencing with Section 1440) of Division 2 of the Health and Safety Code.

(D) A clinic, health dispensary, or health facility licensed pursuant to Division 2 (commencing with Section 1200) of the Health and Safety Code.

(E) Any entity exempt from licensure pursuant to Section 1206 of the Health and Safety Code.

(e) This section shall become ~~operative on July 1, 2000~~ *inoperative on July 1, 2006, and as of January 1, 2007, is repeated, unless a later enacted statute that is enacted before January 1, 2007, deletes or extends the dates on which it becomes inoperative and is repealed*.

SEC. 9. Section 10178.3 is added to the Insurance Code, to read:

10178.3. (a) In order to ensure that providers are able to deliver high quality care to their patients and are able to manage their practices and that fair business practices are in place to provide a more competitive and properly functioning health care delivery system, it is the intent of the Legislature to prevent the unfair selling, leasing, or transferring of a health care provider's contract. It is further the intent of the Legislature that no health care provider shall be paid a discounted rate for health care

services based on that provider's participation in a network or panel unless and until the health care provider has voluntarily agreed in writing, in advance, to the discount with respect to each payor that claims it.

(b) Beginning July 1, 2006, no contracting agent may sell, lease, assign, transfer, or convey its list of contracted health care providers and their contracted reimbursement rates to another payor, as defined in paragraph (5) of subdivision (g), and any such transaction shall be void, unlawful and unenforceable unless all of the following conditions are met:

(1) The contracting agent has a direct contract signed by the provider that meets the following requirements:

(A) Contains model language adopted by the Department of Insurance and the Department of Managed Health Care through emergency regulations setting forth the rights of the provider under this section.

(B) Applies only to a single, as opposed to materially different, product or line of business, and discloses the complete fee schedule applicable to that product or line of business.

(C) Only authorizes the sale, lease, transfer, assignment or conveyance of the provider's name and contracted rates to the extent the provider specifically exercises the option affirmatively in writing to allow his or her name and contracted reimbursement rates to be included on the list of contracted providers that may be sold, leased, transferred, or conveyed to that payor. The written affirmative option to be exercised pursuant to this section shall only be accomplished through a separate document, on the payor summary, or in a separate section in the contract itself, within a box outlined in black, and in a format that enables the provider to affirmatively opt in writing, for each potential payor, whether the provider's name and contracted rate may be sold, leased, transferred or conveyed to that payor through check marks or any other clearly identifiable mechanism. To be an effective authorization, the separate section, document or payor summary shall be signed by the provider. The provider's signature on the contract as a whole does not satisfy this requirement.

(D) Discloses what specific practices, if any, payors utilize to actively encourage a payor's beneficiaries to use the list of

contracted providers when obtaining medical care that entitles a payor to claim a contracted rate.

(E) Clearly discloses whether the contracting agent intends to sell, transfer, lease, assign, or convey the list of contracted providers to any payor that does not actively encourage a payor's beneficiaries to use the list of contracted providers when obtaining medical care. Nothing in this subdivision shall be construed to require a payor to actively encourage the payor's beneficiaries to use the list of contracted providers when obtaining medical care in the case of an emergency.

(F) Allows the provider to terminate his or her authorization with respect to each payor that has access to the provider's name and contracted reimbursement rate on 30 days' written notice.

(G) Discloses all benefits and services the contracting agent will provide to both the provider and payor.

(H) Discloses any fees or other remuneration the contracting agent may receive as a result of the sale, lease, assignment, transfer or conveyance of the list of contracted health care providers.

(2) A contracting agent that obtains a provider's power of attorney shall not transfer that power of attorney to another contracting agent.

(3) The contracting agent discloses, prior to the initial signing of the contract, a payor summary of all payors that seek to be eligible to claim a provider's contracted rate if the provider affirmatively opts in its written agreement with the contracting agent to allow his or her name and contracted reimbursement rate to be sold, leased, transferred, or conveyed to that payor.

(4) The contracting agent discloses the provider's current payor summary at least annually, and within 30 calendar days of receipt of a written request from a provider.

(5) The contracting agent discloses by registered or certified mail a payor summary of any additional payors that seek to be eligible to claim a provider's contracted rate due to the provider's written agreement with the contracting agent.

(6) The contracting agent does not transfer, sell, assign, lease, or convey the list of contracted providers to any entity that is not a payor, or include on the list any provider that has not affirmatively agreed in writing to specifically authorize that

payor to have access to the provider's name and contracted reimbursement rate.

(7) The contracting agent does not allow the payor to transfer, sell, assign, lease or convey the list of contracted providers to any other payor or entity.

(8) The contracting agent requires those payors that are eligible to claim a provider's contracted rate to cease claiming entitlement to that rate upon termination of the provider's underlying contract, or termination of the provider's authorization to allow that payor to continue to have access to the provider's name and contracted reimbursement rate.

(9) The contracting agent provides to the payor, upon a payor's request where its entitlement to a discount is being challenged, a copy of the agreement whereby the provider affirmatively agreed in writing to specifically authorize that payor to have access to that provider's name and contracted reimbursement rate.

(10) The activity does not violate any other provision of law.

(11) The contracting agent may only receive access fees or other remuneration for the sale, lease, transfer, or conveyance of a provider's name and contracted rate as long as the list of contracted providers is sold, transferred, leased, or conveyed to a payor that actively encourages a payor's beneficiaries to use the list of contracted providers when obtaining medical care.

(c) A provider shall be free to allow or decline the sale, leasing, transfer, or conveyance of the provider's name and contracted reimbursement rate with respect to each potential payor without penalty, sanction, or retaliation of any kind, including exclusion from the contracting agent's network.

(d) No payor shall be eligible to claim a provider's contracted rate unless the payor's name has been identified on the payor summary provided by the contracting agent and the provider has affirmatively opted in writing to allow that payor to use that rate.

(e) Beginning July 1, 2006, a payor, as defined in paragraph (5) of subdivision (g), that claims eligibility to a provider's contracted rate shall do all of the following:

(1) Include on the explanation of benefits, remittance advice, and any other explanation of review the identity of the contracting agent through which the discount is claimed, as well as the names and telephone numbers of the individual or unit

responsible for provider contracting for the contracting agent identified on the patient's insurance card that has a written agreement signed by the provider who submitted the claim whereby the payor is directly entitled to pay a preferred rate for the services rendered.

(2) Demonstrate that it is entitled to pay a contracted rate within 30 business days of receipt of a written request from a provider who has received a claim payment from the payor. A payor can initially determine such entitlement where it provides all of the following:

(A) Documentation of the name of the contracting agent and telephone number of the individual or unit responsible for provider contracting that has the written agreement signed by the provider whereby the provider affirmatively opted to accept discounted rates from the payor in question to be furnished to that provider.

(B) Documentation that the contract was not sold, leased, transferred, assigned, or conveyed to a payor for a product or business line that is materially different from that to which the underlying contract applies as it relates to increased workload or other responsibilities imposed or as it relates to decreased benefits conferred on the provider.

(C) Documentation that the patient to whom the services were provided was covered by the product or business line with respect to which the provider agreed to authorize discounts.

(D) Documentation that the patient was covered by an entity authorized to claim a discount.

(E) Documentation that the underlying contract is with a provider that has the same tax or employer identification number as that of the provider's practice that submitted the claim at issue. The failure of a payor to make the demonstration within 30 business days shall render the payor responsible for the amount that the payor would have been required to pay pursuant to the contract between the payor and the beneficiary, which shall be due and payable within 10 business days of receipt of written notice from the provider, and shall bar the payor from taking any future discounts from that provider without the provider's express written consent until the payor can demonstrate to the provider that it is entitled to pay a contracted rate as provided in this paragraph.

(f) A payor's initial determination that it is entitled to pay a contracted rate is deemed refuted where the provider provides any of the following:

(1) Documentation that the provider opted not to be on the list of contracted providers at issue.

(2) Documentation that the provider terminated the underlying contract.

(3) Documentation that the contract was sold, leased, transferred, assigned or conveyed to a payor for a product or business line that is materially different from that to which the underlying contract applies as it relates to increased workload or other responsibilities imposed or as it relates to decreased benefits conferred on the provider.

(4) Documentation that the patient was not covered by an entity authorized to claim a discount.

(5) Documentation that the underlying contract is with a provider that has a different tax or employer identification number than that of the provider's practice that submitted the claim at issue.

(g) For the purposes of this section, the following terms have the following meanings:

(1) "Actively encouraged its beneficiaries to use the list of contracted providers" means either of the following requirements are met:

(A) The payor's contract with subscribers or insureds offers beneficiaries direct financial incentives to use the list of contracted providers when obtaining medical care. "Financial incentives" means reduced copayments, reduced deductibles, premium discounts directly attributable to the use of a provider panel, or financial penalties directly attributable to the nonuse of a provider panel.

(B) The payor provides information directly to its beneficiaries advising them of the existence of the list of contracted providers through the use of a variety of advertising or marketing approaches that supply the names, addresses, and telephone numbers of contracted providers to beneficiaries in advance of their selection of a health care provider, which approaches may include, but are not limited to, the use of provider directories, or the use of toll-free telephone numbers or Internet Web site addresses supplied directly to every beneficiary. However,

Internet Web site addresses alone shall not be deemed to satisfy the requirements of this subparagraph. Nothing in this subparagraph shall prevent contracting agents or payors from providing only listings of providers located within a reasonable geographic range of a beneficiary.

(2) "Beneficiary" means the following:

(A) For workers' compensation insurance, an employee seeking health care services for a work-related injury.

(B) For automobile insurance, those persons covered under the medical payments portion of the insurance contract.

(C) For group or individual health services covered through a health care service plan contract, including a specialized health care service plan contract, or a policy of disability insurance that covers hospital, medical, or surgical benefits, a subscriber, an enrollee, a policyholder, or an insured.

(3) "Contracting agent" means an insurer licensed under this code to provide disability insurance that covers hospital, medical, or surgical benefits, automobile insurance, or workers' compensation insurance, or any other entity while engaged, for monetary or other consideration, in the act of selling, leasing, transferring, assigning, or conveying a provider or provider panel to provide health care services to beneficiaries. A contracting agent shall not include either of the following:

(A) A group of health care providers organized as a partnership or professional corporation that contracts with only one health care service plan to provide or arrange for the provision of health care services to that plan's members.

(B) A hospital corporation that has an identical board of directors with a health plan that exclusively contracts with the group of providers described in subparagraph (A) to provide professional medical services to its enrollees.

(4) "Materially different" means a network, product, or business line that a reasonable provider would attach importance to in determining whether to participate in it, including, but not limited to, in addition to the fee schedule amount, the types of services to be provided, claims processing rules, utilization review procedures, and patient collection processes.

(5) "Payor" means a health care service plan, including a specialized health care service plan, an insurer licensed under

this code to provide disability insurance that covers hospital, medical, or surgical benefits, automobile insurance, workers' compensation insurance, or a self-insured employer that is responsible to pay for health care services provided to beneficiaries. "Payor" also means only those entities that provide coverage for hospital, medical, or surgical benefits that are not regulated under the Health and Safety Code, this code, or the Labor Code.

(6) "Payor summary" means a written summary that includes the payor's name, the type of plan, including, but not limited to, a group health plan, an automobile insurance plan, and a workers' compensation insurance plan, and the specific practices, if any, the payor utilizes to actively encourage a payor's beneficiaries to use the list of contracted providers when obtaining medical care and the identity and telephone number for the individual or office responsible for handling provider reimbursement. The payor summary shall clearly identify each payor that does not actively encourage its beneficiaries to do so. The payor summary must be set forth within a box outlined in black and in a format that provides the opportunity for the provider to affirmatively opt in writing to allow or decline the sale, transfer, lease, or conveyance of the provider's name and contracted rates with respect to each payor on the summary, through check marks or any other clearly identifiable mechanism, and, to the extent the provider has already made this election, clearly discloses each such election that the provider has made. The payor summary shall be signed by the provider.

(7) "Provider" means any of the following:

(A) A person licensed or certified pursuant to this division.

(B) A person licensed pursuant to the Chiropractic Initiative Act or the Osteopathic Initiative Act.

(C) A person licensed pursuant to Chapter 2.5 (commencing with Section 1440) of Division 2 of the Health and Safety Code.

(D) A clinic, health dispensary, or health facility licensed pursuant to Division 2 (commencing with Section 1200) of the Health and Safety Code.

(E) Any entity exempt from licensure pursuant to Section 1206 of the Health and Safety Code.

(g) This section shall become operative July 1, 2006.

SEC. 10. Section 10178.4 of the Insurance Code is amended to read:

10178.4. (a) When a contracting agent sells, leases, or transfers a health provider's contract to a payor, the rights and obligations of the provider shall be governed by the underlying contract between the health care provider and the contracting agent.

(b) *Notwithstanding any other provision of law, the underlying contract shall not obligate a provider to participate in materially different networks, products, or business lines, nor authorize, or otherwise require the provider to consent to the sale, lease, transfer, assignment or conveyance of the contracted list of providers to any network, product, or business line that is materially different from that to which the underlying contract applies, either as it relates to increased workload or other responsibilities imposed on the provider or as it relates to any decreased benefits conferred on the provider. "Materially different" for the purposes of this section means a network, product, or business line that a reasonable provider would attach importance to in determining whether to participate in it, including, but not limited to, in addition to the fee schedule amount, the types of services to be provided, claims processing and payment rules, utilization review procedures, or patient collection processes.*

(c) For purposes of this section, the following terms shall have the following meanings:

(1) "Contracting agent" has the meaning set forth in ~~paragraph (2) of subdivision (d) of~~ Section 10178.3.

(2) "Payor" has the meaning set forth in ~~paragraph (3) of subdivision (d) of~~ Section 10178.3.

SEC. 11. Section 4609 of the Labor Code is amended to read:

4609. (a) In order to prevent the improper selling, leasing, or transferring of a health care provider's contract, it is the intent of the Legislature that every arrangement that results in any payor paying a health care provider a reduced rate for health care services based on the health care provider's participation in a network or panel shall be disclosed by the contracting agent to the provider in advance and shall actively encourage employees to use the network, unless the health care provider agrees to provide discounts without that active encouragement.

(b) Beginning July 1, 2000, every contracting agent that sells, leases, assigns, transfers, or conveys its list of contracted health care providers and their contracted reimbursement rates to a payor, as defined in subparagraph (A) of paragraph (3) of subdivision (d), or another contracting agent shall, upon entering or renewing a provider contract, do all of the following:

(1) Disclose whether the list of contracted providers may be sold, leased, transferred, or conveyed to other payors or other contracting agents, and specify whether those payors or contracting agents include workers' compensation insurers or automobile insurers.

(2) Disclose what specific practices, if any, payors utilize to actively encourage employees to use the list of contracted providers when obtaining medical care that entitles a payor to claim a contracted rate. For purposes of this paragraph, a payor is deemed to have actively encouraged employees to use the list of contracted providers if the employer provides information directly to employees during the period the employer has medical control advising them of the existence of the list of contracted providers through the use of a variety of advertising or marketing approaches that supply the names, addresses, and telephone numbers of contracted providers to employees; or in advance of a workplace injury, or upon notice of an injury or claim by an employee, the approaches may include, but are not limited to, the use of provider directories, the use of a list of all contracted providers in an area geographically accessible to the posting site, the use of wall cards that direct employees to a readily accessible listing of those providers at the same location as the wall cards, the use of wall cards that direct employees to a toll-free telephone number or Internet Web site address, or the use of toll-free telephone numbers or Internet Web site addresses supplied directly during the period the employer has medical control. However, Internet Web site addresses alone shall not be deemed to satisfy the requirements of this paragraph. Nothing in this paragraph shall prevent contracting agents or payors from providing only listings of providers located within a reasonable geographic range of an employee. A payor who otherwise meets the requirements of this paragraph is deemed to have met the requirements of this paragraph regardless of the employer's

ability to control medical treatment pursuant to Sections 4600 and 4600.3.

(3) Disclose whether payors to which the list of contracted providers may be sold, leased, transferred, or conveyed may be permitted to pay a provider's contracted rate without actively encouraging the employees to use the list of contracted providers when obtaining medical care. Nothing in this subdivision shall be construed to require a payor to actively encourage the employees to use the list of contracted providers when obtaining medical care in the case of an emergency.

(4) Disclose, upon the initial signing of a contract, and within 15 business days of receipt of a written request from a provider or provider panel, a payor summary of all payors currently eligible to claim a provider's contracted rate due to the provider's and payor's respective written agreements with any contracting agent.

(5) Allow providers, upon the initial signing, renewal, or amendment of a provider contract, to decline to be included in any list of contracted providers that is sold, leased, transferred, or conveyed to payors that do not actively encourage the employees to use the list of contracted providers when obtaining medical care as described in paragraph (2). Each provider's election under this paragraph shall be binding on the contracting agent with which the provider has the contract and any other contracting agent that buys, leases, or otherwise obtains the list of contracted providers.

A provider shall not be excluded from any list of contracted providers that is sold, leased, transferred, or conveyed to payors that actively encourage the employees to use the list of contracted providers when obtaining medical care, based upon the provider's refusal to be included on any list of contracted providers that is sold, leased, transferred, or conveyed to payors that do not actively encourage the employees to use the list of contracted providers when obtaining medical care.

(6) If the payor's explanation of benefits or explanation of review does not identify the name of the network that has a written agreement signed by the provider whereby the payor is entitled, directly or indirectly, to pay a preferred rate for the services rendered, the contracting agent shall do the following:

(A) Maintain a Web site that is accessible to all contracted providers and updated at least quarterly and maintain a toll-free telephone number accessible to all contracted providers whereby providers may access payor summary information.

(B) Disclose through the use of an Internet Web site, a toll-free telephone number, or through a delivery or mail service to its contracted providers, within 30 days, any sale, lease assignment, transfer or conveyance of the contracted reimbursement rates to another contracting agent or payor.

(7) Nothing in this subdivision shall be construed to impose requirements or regulations upon payors, as defined in subparagraph (A) of paragraph (3) of subdivision (d).

(c) Beginning July 1, 2000, a payor, as defined in subparagraph (B) of paragraph (3) of subdivision (d), shall do all of the following:

(1) Provide an explanation of benefits or explanation of review that identifies the name of the network with which the payor has an agreement that entitles them to pay a preferred rate for the services rendered.

(2) Demonstrate that it is entitled to pay a contracted rate within 30 business days of receipt of a written request from a provider who has received a claim payment from the payor. The provider shall include in the request a statement explaining why the payment is not at the correct contracted rate for the services provided. The failure of the provider to include a statement shall relieve the payor from the responsibility of demonstrating that it is entitled to pay the disputed contracted rate. The failure of a payor to make the demonstration to a properly documented request of the provider within 30 business days shall render the payor responsible for the lesser of the provider's actual fee or, as applicable, any fee schedule pursuant to this division, which amount shall be due and payable within 10 days of receipt of written notice from the provider, and shall bar the payor from taking any future discounts from that provider without the provider's express written consent until the payor can demonstrate to the provider that it is entitled to pay a contracted rate as provided in this subdivision. A payor shall be deemed to have demonstrated that it is entitled to pay a contracted rate if it complies with either of the following:

(A) Describes the specific practices the payor utilizes to comply with paragraph (2) of subdivision (b), and demonstrates compliance with paragraph (1).

(B) Identifies the contracting agent with whom the payor has a written agreement whereby the payor is not required to actively encourage employees to use the list of contracted providers pursuant to paragraph (5) of subdivision (b).

(d) For the purposes of this section, the following terms have the following meanings:

(1) "Contracting agent" means an insurer licensed under the Insurance Code to provide workers' compensation insurance, a health care service plan, including a specialized health care service plan, a preferred provider organization, or a self-insured employer, while engaged, for monetary or other consideration, in the act of selling, leasing, transferring, assigning, or conveying a provider or provider panel to provide health care services to employees for work-related injuries.

(2) "Employee" means a person entitled to seek health care services for a work-related injury.

(3) (A) For the purposes of subdivision (b), "payor" means a health care service plan, including a specialized health care service plan, an insurer licensed under the Insurance Code to provide disability insurance that covers hospital, medical, or surgical benefits, automobile insurance, or workers' compensation insurance, or a self-insured employer that is responsible to pay for health care services provided to beneficiaries.

(B) For the purposes of subdivision (c), "payor" means an insurer licensed under the Insurance Code to provide workers' compensation insurance, a self-insured employer, a third-party administrator or trust, or any other third party that is responsible to pay health care services provided to employees for work-related injuries, or an agent of an entity included in this definition.

(4) "Payor summary" means a written summary that includes the payor's name and the type of plan, including, but not limited to, a group health plan, an automobile insurance plan, and a workers' compensation insurance plan.

(5) "Provider" means any of the following:

(A) Any person licensed or certified pursuant to Division 2 (commencing with Section 500) of the Business and Professions Code.

(B) Any person licensed pursuant to the Chiropractic Initiative Act or the Osteopathic Initiative Act.

(C) Any person licensed pursuant to Chapter 2.5 (commencing with Section 1440) of Division 2 of the Health and Safety Code.

(D) A clinic, health dispensary, or health facility licensed pursuant to Division 2 (commencing with Section 1200) of the Health and Safety Code.

(E) Any entity exempt from licensure pursuant to Section 1206 of the Health and Safety Code.

(e) This section shall become ~~operative on July 1, 2000~~ *inoperative on July 1, 2006, and as of January 1, 2007, is repealed, unless a later enacted statute that is enacted before January 1, 2007, deletes or extends the dates on which it becomes inoperative and is repealed.*

SEC. 12. Section 4609 is added to the Labor Code, to read:

4609. (a) In order to ensure that providers are able to deliver high quality care to their patients and are able to manage their practices and that fair business practices are in place to provide a more competitive and properly functioning health care delivery system, it is the intent of the Legislature to prevent the unfair selling, leasing, or transferring of a health care provider's contract. It is further the intent of the Legislature that no health care provider shall be paid a discounted rate for health care services based on that provider's participation in a network or panel unless and until the health care provider has voluntarily agreed in writing, in advance, to the discount with respect to each payor that claims it.

(b) Beginning July 1, 2006, no contracting agent may sell, lease, assign, transfer, or convey its list of contracted health care providers and their contracted reimbursement rates to another payor, as defined in paragraph (5) of subdivision (g), and any such transaction shall be void, unlawful and unenforceable unless all of the following conditions are met:

(1) The contracting agent has a direct contract signed by the provider that meets the following requirements:

(A) Contains model language adopted by the Department of Insurance and the Department of Managed Health Care through

emergency regulations setting forth the rights of the provider under this section.

(B) Applies only to a single, as opposed to materially different, product or line of business, and discloses the complete fee schedule applicable to that product or line of business.

(C) Only authorizes the sale, lease, transfer, assignment or conveyance of the provider's name and contracted rates to the extent the provider specifically exercises the option affirmatively in writing to allow his or her name and contracted reimbursement rates to be included on the list of contracted providers that may be sold, leased, transferred, or conveyed to that payor. The written affirmative option to be exercised pursuant to this section shall only be accomplished through a separate document, on the payor summary, or in a separate section in the contract itself, within a box outlined in black, and in a format that enables the provider to affirmatively opt in writing, for each potential payor, whether the provider's name and contracted rate may be sold, leased, transferred or conveyed to that payor through check marks or any other clearly identifiable mechanism. To be an effective authorization, the separate section, document or payor summary shall be signed by the provider. The provider's signature on the contract as a whole does not satisfy this requirement.

(D) Discloses what specific practices, if any, payors utilize to actively encourage a payor's beneficiaries to use the list of contracted providers when obtaining medical care that entitles a payor to claim a contracted rate.

(E) Clearly discloses whether the contracting agent intends to sell, transfer, lease, assign, or convey the list of contracted providers to any payor that does not actively encourage a payor's beneficiaries to use the list of contracted providers when obtaining medical care. Nothing in this subdivision shall be construed to require a payor to actively encourage the payor's beneficiaries to use the list of contracted providers when obtaining medical care in the case of an emergency.

(F) Allows the provider to terminate his or her authorization with respect to each payor that has access to the provider's name and contracted reimbursement rate on 30 days' written notice.

(G) Discloses all benefits and services the contracting agent will provide to both the provider and payor.

(H) Discloses any fees or other remuneration the contracting agent may receive as a result of the sale, lease, assignment, transfer or conveyance of the list of contracted health care providers.

(2) A contracting agent that obtains a provider's power of attorney shall not transfer that power of attorney to another contracting agent.

(3) The contracting agent discloses, prior to the initial signing of the contract, a payor summary of all payors that seek to be eligible to claim a provider's contracted rate if the provider affirmatively opts in its written agreement with the contracting agent to allow his or her name and contracted reimbursement rate to be sold, leased, transferred, or conveyed to that payor.

(4) The contracting agent discloses the provider's current payor summary at least annually, and within 30 calendar days of receipt of a written request from a provider.

(5) The contracting agent discloses by registered or certified mail a payor summary of any additional payors that seek to be eligible to claim a provider's contracted rate due to the provider's written agreement with the contracting agent.

(6) The contracting agent does not transfer, sell, assign, lease, or convey the list of contracted providers to any entity that is not a payor, or include on the list any provider that has not affirmatively agreed in writing to specifically authorize that payor to have access to the provider's name and contracted reimbursement rate.

(7) The contracting agent does not allow the payor to transfer, sell, assign, lease or convey the list of contracted providers to any other payor or entity.

(8) The contracting agent requires those payors that are eligible to claim a provider's contracted rate to cease claiming entitlement to that rate upon termination of the provider's underlying contract, or termination of the provider's authorization to allow that payor to continue to have access to the provider's name and contracted reimbursement rate.

(9) The contracting agent provides to the payor, upon a payor's request where its entitlement to a discount is being challenged, a copy of the agreement whereby the provider affirmatively agreed in writing to specifically authorize that

payor to have access to that provider's name and contracted reimbursement rate.

(10) The activity does not violate any other provision of law.

(11) The contracting agent may only receive access fees or other remuneration for the sale, lease, transfer, or conveyance of a provider's name and contracted rate as long as the list of contracted providers is sold, transferred, leased or conveyed to a payor that actively encourages a payor's beneficiaries to use the list of contracted providers when obtaining medical care.

(c) A provider shall be free to allow or decline the sale, leasing, transfer, or conveyance of the provider's name and contracted reimbursement rate with respect to each potential payor, without penalty, sanction, or retaliation of any kind, including exclusion from the contracting agent's network.

(d) No payor shall be eligible to claim a provider's contracted rate unless the payor's name has been identified on the payor summary provided by the contracting agent and the provider has affirmatively opted in writing to allow that payor to use that rate.

(e) Beginning July 1, 2006, a payor, as defined in paragraph (5) of subdivision (g), that claims eligibility to a provider's contracted rate shall do all of the following:

(1) Include on the explanation of benefits, remittance advice, and any other explanation of review the identity of the contracting agent through which the discount is claimed, as well as the names and telephone numbers of the individual or unit responsible for provider contracting for the contracting agent identified on the patient's insurance card that has a written agreement signed by the provider who submitted the claim whereby the payor is directly entitled to pay a preferred rate for the services rendered.

(2) Demonstrate that it is entitled to pay a contracted rate within 30 business days of receipt of a written request from a provider who has received a claim payment from the payor. A payor can initially determine such entitlement where it provides all of the following:

(A) Documentation of the name of the contracting agent and telephone number of the individual or unit responsible for provider contracting that has the written agreement signed by the provider whereby the provider affirmatively opted to accept

discounted rates from the payor in question to be furnished to that provider.

(B) Documentation that the contract was not sold, leased, transferred, assigned or conveyed to a payor for a product or business line that is materially different from that to which the underlying contract applies as it relates to increased workload or other responsibilities imposed or as it relates to decreased benefits conferred on the provider.

(C) Documentation that the patient to whom the services were provided was covered by the product or business line with respect to which the provider agreed to authorize discounts.

(D) Documentation that the patient was covered by an entity authorized to claim a discount.

(E) Documentation that the underlying contract is with a provider that has the same tax or employer identification number as that of the provider's practice that submitted the claim at issue. The failure of a payor to make the demonstration within 30 business days shall render the payor responsible for the amount that the payor would have been required to pay pursuant to the contract between the payor and the beneficiary, which shall be due and payable within 10 business days of receipt of written notice from the provider, and shall bar the payor from taking any future discounts from that provider without the provider's express written consent until the payor can demonstrate to the provider that it is entitled to pay a contracted rate as provided in this paragraph.

(f) A payor's initial determination that it is entitled to pay a contracted rate is deemed refuted where the provider provides any of the following:

(1) Documentation that the provider opted not to be on the list of contracted providers at issue.

(2) Documentation that the provider terminated the underlying contract.

(3) Documentation that the contract was sold, leased, transferred, assigned or conveyed to a payor for a product or business line that is materially different from that to which the underlying contract applies as it relates to increased workload or other responsibilities imposed or as it relates to decreased benefits conferred on the provider.

(4) Documentation that the patient was not covered by an entity authorized to claim a discount.

(5) Documentation that the underlying contract is with a provider that has a different tax or employer identification number than that of the provider's practice that submitted the claim at issue.

(g) For the purposes of this section, the following terms have the following meanings:

(1) "Actively encouraged its beneficiaries to use the list of contracted providers" means either of the following requirements are met:

(A) The payor's contract with subscribers or insureds offers beneficiaries direct financial incentives to use the list of contracted providers when obtaining medical care. "Financial incentives" means reduced copayments, reduced deductibles, premium discounts directly attributable to the use of a provider panel, or financial penalties directly attributable to the nonuse of a provider panel.

(B) The payor provides information directly to its beneficiaries advising them of the existence of the list of contracted providers through the use of a variety of advertising or marketing approaches that supply the names, addresses, and telephone numbers of contracted providers to beneficiaries in advance of their selection of a health care provider, which approaches may include, but are not limited to, the use of provider directories, or the use of toll-free telephone numbers or Internet Web site addresses supplied directly to every beneficiary. However, Internet Web site addresses alone shall not be deemed to satisfy the requirements of this subparagraph. Nothing in this subparagraph shall prevent contracting agents or payors from providing only listings of providers located within a reasonable geographic range of a beneficiary.

(2) "Contracting agent" means an insurer licensed under the Insurance Code to provider workers' compensation insurance, a health care service plan, including a specialized health care service plan, a preferred provider organization, or a self-insured employer, or any other entity while engaged, for monetary or other consideration, in the act of selling, leasing, transferring, assigning, or conveying a provider or provider panel to provide

health care services to employees for work-related injuries. A contracting agent shall not include either of the following:

(A) A group of health care providers organized as a partnership or professional corporation that contracts with only one health care service plan to provide or arrange for the provision of health care services to that plan's members.

(B) A hospital corporation that has an identical board of directors with a health plan that exclusively contracts with the group of providers described in subparagraph (A) to provide professional medical services to its enrollees.

(3) "Employee" means a person entitled to seek health care services for a work-related injury.

(4) "Materially different" means a network, product, or business line that a reasonable provider would attach importance to in determining whether to participate in it, including, but not limited to, in addition to the fee schedule amount, the types of services to be provided, claims processing rules, utilization review procedures, or patient collection processes.

(5) "Payor" means a health care service plan, including a specialized health care service plan, an insurer licensed under the Insurance Code to provide disability insurance that covers hospital, medical, or surgical benefits, automobile insurance, workers' compensation insurance, or a self-insured employer that is responsible to pay for health care services provided to beneficiaries. "Payor" also means only those entities that provide coverage for hospital, medical, or surgical benefits that are not regulated under the Health and Safety Code, the Insurance Code, or this code.

(6) "Payor summary" means a written summary that includes the payor's name, the type of plan, including, but not limited to, a group health plan, an automobile insurance plan, and a workers' compensation insurance plan, and the specific practices, if any, the payor utilizes to actively encourage a payor's beneficiaries to use the list of contracted providers when obtaining medical care and the identity and telephone number for the individual or office responsible for handling provider reimbursement. The payor summary shall clearly identify each payor that does not actively encourage its beneficiaries to do so. The payor summary must be set forth within a box outlined in

black, and in a format that provides the opportunity for the provider to affirmatively opt in writing to allow or decline the sale, transfer, lease, or conveyance of the provider's name and contracted rates with respect to each payor on the summary, through check marks or any other clearly identifiable mechanism, and, to the extent the provider has already made this election, clearly discloses each such election the provider has made. The payor summary shall be signed by the provider.

(7) "Provider" means any of the following:

(A) A person licensed or certified pursuant to this division.

(B) A person licensed pursuant to the Chiropractic Initiative Act or the Osteopathic Initiative Act.

(C) A person licensed pursuant to Chapter 2.5 (commencing with Section 1440) of Division 2 of the Health and Safety Code.

(D) A clinic, health dispensary, or health facility licensed pursuant to Division 2 (commencing with Section 1200) of the Health and Safety Code.

(E) An entity exempt from licensure pursuant to Section 1206 of the Health and Safety Code.

(h) This section shall become operative on July 1, 2006.

SEC. 13. Section 4609.5 is added to the Labor Code, to read:

4609.5. (a) When a contracting agent sells, leases, or transfers a health provider's contract to a payor, the rights and obligations of the provider shall be governed by the underlying contract between the health care provider and the contracting agent.

(b) Notwithstanding any other provision of law, the underlying contract shall not obligate a provider to participate in materially different networks, products, or business lines, nor authorize, or otherwise require the provider to consent to the sale, lease, transfer, assignment or conveyance of the contracted list of providers to any network, product, or business line that is materially different from that to which the underlying contract applies, either as it relates to increased workload or other responsibilities imposed on the provider or as it relates to any decreased benefits conferred on the provider. "Materially different" for the purposes of this section means a network, product, or business line that a reasonable provider would attach importance to in determining whether to participate in it, including, but not limited to, in addition to the fee schedule

amount, the types of services to be provided, claims processing and payment rules, utilization review procedures, or patient collection processes.

(c) For purposes of this section, the following terms shall have the following meanings:

(1) "Contracting agent" has the meaning set forth in Section 4609.

(2) "Payor" has the meaning set forth in Section 4609.

SEC. 14. No reimbursement is required by this act pursuant to Section 6 of Article XIII B of the California Constitution because the only costs that may be incurred by a local agency or school district will be incurred because this act creates a new crime or infraction, eliminates a crime or infraction, or changes the penalty for a crime or infraction, within the meaning of Section 17556 of the Government Code, or changes the definition of a crime within the meaning of Section 6 of Article XIII B of the California Constitution.

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